ANNUAL REPORT

FOR THE YEAR ENDED

MARCH 31, 1974

MEDICAL SERVICES COMMISSION

OF BRITISH COLUMBIA

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ANNUAL REPORT

FOR THE YEAR ENDED

MARCH 31, 1974

MEDICAL SERVICES COMMISSION

OF BRITISH COLUMBIA

104-05227/

VICTORIA, B.C., December 16, 1974.

To His Honour the Lieutenant-Governor of the
Province of British Columbia:

MAY IT PLEASE YOUR HONOUR:

I have the honour, sir, to submit herewith the report of the Medical Services Commission for the fiscal year ended March 31, 1974.

I have the honour to be,

Sir

Your most obedient servant,

DENNIS COCKE
Minister of Health

VICTORIA, B.C., December 16, 1974.

The Honourable Dennis Cocke,
Minister of Health.

SIR: I have the honour to submit the Annual Report of the Medical Services Commission for the fiscal year ended March 31, 1974.

G. A. STEWART
Chairman

THE BRITISH COLUMBIA MEDICAL SERVICES COMMISSION

Minister

THE HONOURABLE DENNIS G. COCKE, Minister of Health

Members of the Commission

G. A. Stewart, Chairman
G. S. Bryson, B.Com., F.C.I.S., Deputy Minister of Finance
A. M. Johnson, M.D., F.R.C.P.(C)

Administrative Staff

D. H. Weir, B.A., C.G.A., Assistant to the Chairman
W. Brennan, Administrative Officer, Accounting and Finance
C. A. McQuarrie, Systems Analyst
D. W. Nimmo, Administrative Officer, Vancouver
J. M. Sotkowy, Administrative Officer, General Administration
Mrs. C. A. Delozier, B.Sc.
J. Berry, Inspector

Senior Medical Adviser

C. R. Arnold, B.A., M.D., F.R.C.P.C., F.A.C.P.

*Licensed Carriers**

The British Columbia Medical Plan (B.C.M.P.)
C.U. & C. Health Services Society (C.U. & C.)
Medical Services Association (M.S.A.)

* All staff of the licensed carrier B.C.M.P. are staff of the Medical Services Commission and are public servants. The head of the medical claims department in M.S.A. and C.U. & C. is an employee of the Commission but is not a public servant.

Annual Report of the Medical Services Commission of British Columbia

I. INTRODUCTION

The Government of the Province established, effective July 1, 1968, an overall Medical Services Plan which is administered and operated on a nonprofit basis in accordance with the *Medical Services Act* and regulations by and under the supervision of the Medical Services Commission. The Commission is empowered to function as the public authority appointed by the Government of the Province to be responsible to the Minister in respect of the administration and operation of the Plan established under the regulations.

The Medical Services Plan of British Columbia provides a prepaid medical services plan upon uniform terms and conditions for all residents of the Province and their dependants. Insured services under the Plan are paid for insured persons regardless of age, state of health, or financial circumstances, provided the premiums fixed by the Commission are paid. Payment of these services is made, on a fee for services basis according to a tariff of fees approved or prescribed by the Commission, or by salaried, sessional, or contract basis at levels approved by the Commission.

II. BENEFITS UNDER THE PLAN

A. Basic Medical Services

The Medical Services Plan provides insurance coverage for all medically required services rendered by medical practitioners* and certain surgical procedures of dental surgeons where necessarily performed in a hospital as provided under the *Medical Care Act* of Canada. A contribution from the Federal Government is payable to the Province toward the cost of these insured services on the basis of 50 per cent of the national *per capita* cost of these services multiplied by the average number of insured persons in the Province during the 12-month period ending on the 31st day of March.

B. Additional Benefits

In addition to payment for the above services, additional benefits, when rendered in the Province, are provided without extra premium by the Government of British Columbia. The Federal Government does not share in these costs. All payments are paid only at a tariff of fees approved by the Commission. "Year" means calendar year. A brief description of these additional benefits follows, for exact details *see* the Medical Services Act Regulations.

1. *Chiropractic*—Payment for the services of a registered chiropractor is limited in any one year to a total of $75 per patient under the age of 65 years and $100 per patient 65 years of age or over:

No payment for X-rays taken by a chiropractor:

No payment for any chiropractic service performed outside the Province.

2. *Naturopathic*—Payment for services of a naturopathic physician is limited to a total of $50 per patient in any one year and a maximum of $100 per family in any one year:

No payment for X-rays taken by a naturopathic physician:

No payment for any naturopathic services performed outside the Province.

* In British Columbia, osteopathic physicians are included as medical practitioners.

3. *Orthoptic treatment*—Up to a limit of $50 per patient in any one year and a maximum of $100 per family in any one year, services for orthoptic treatments when rendered in the Province of British Columbia to an insured person on the instructions of, or referral by a medical practitioner, shall be paid under the Plan at a tariff of fees approved by the Commission, but there shall be no payment for such services performed outside the Province of British Columbia.

4. *Physiotherapy*—Payment for the services of a registered physiotherapist on the instructions of, or referral by, a medical practitioner where performed other than in general or rehabilitative hospitals, is limited to a total of $50 per patient in any one year and a maximum of $100 per family in any one year: No payment for any services performed outside the Province.

IMPORTANT—Out-patient physiotherapy services in general hospitals or in rehabilitative hospitals on referral by a medical practitioner are benefits provided by the British Columbia Hospital Insurance Service.

5. *Podiatry*—Payment for services of a registered podiatrist is limited to $50 per patient in any one year and a maximum of $100 per family in any one year, when rendered other than on the instructions of, or referral by, a medical practitioner within the year.

No payment for X-rays taken by a podiatrist:

No payment for any services performed outside the Province.

6. *Optometry*—Services of registered optometrists are approved for required diagnostic optometric services to determine the presence of any observed abnormality in the visual system. There is no payment for any service performed outside the Province of British Columbia by an optometrist. The Plan does not pay for the fitting or cost of lenses.

7. *Orthodontic*—Service, provided by a dental surgeon for an insured person 20 years of age or younger and which is consequentially necessary in the care of a cleft lip and (or) cleft palate is paid only where that service arises as part of or following plastic surgery repair performed by a medical practitioner. There is no payment for orthodontic services provided outside the Province. There is no payment for dentures, appliances, prostheses, or for general dental services.

8. *Special nursing*—Special nursing services of a registered nurse shall be paid, including the cost of board, to a maximum of $40 per patient in any one year, but only where such services are deemed advisable by a medical practitioner. There shall be no payment for such services performed outside the Province of British Columbia.

9. *Victorian Order of Nursing*—The services of a member of the Victorian Order of Nurses, acting under or with an attending medical practitioner, shall be paid under the Plan at a rate of $2 net per visit to a maximum of $40 per patient per year, but this limit will not apply to the administering of injections on the instructions of a physician. There shall be no payment for any service performed outside the Province of British Columbia by a member of the Victorian Order of Nurses.

III. SERVICES EXCLUDED UNDER THE PLAN

1. Services which are provided under other Federal or Provincial Acts such as the *National Defence Act* of Canada, the *Hospital Insurance Act*, and the *Workers' Compensation Act* of the Province.

2. Pathology, radiology, and (or) electrodiagnostic services performed within the Province at a laboratory that, at the time the service is rendered, is not an approved laboratory for the performance of the service.

3. Services which are not considered to be medically required by the patient, e.g., cosmetic services, examinations at the request of a third party, medico-legal services, advice by telephone, travel charges of a practitioner.

4. While unexpected medical services arising when an insured person is temporarily absent from British Columbia are covered at British Columbia rates, prior authorization in writing from a Medical Director of the Plan is required where the insured person elects to seek medical attention outside the Province, otherwise payment may not be made under the Plan.

IV. PREMIUM RATES AND ASSISTANCE

For those persons having maintained a permanent residence in British Columbia for the 12 consecutive months immediately prior to making application, and who otherwise qualify as eligible under the Medical Grant Act Regulations, premium assistance under the *Medical Grant Act* is available as follows:

(*a*) Applicants who were not liable to pay income tax in the 12 months ending December 31 of the previous year qualify for a subsidy of 90 per cent of the full premium rate:

(*b*) Applicants whose taxable income in the 12 months ending December 31 of the previous year did not exceed $1,000 qualify for a subsidy of 50 per cent of the full premium rates.

Monthly premiums payable by subscribers are as follows:

	Full Premium	If Qualified for— 50 Per Cent Subsidy	90 Per Cent Subsidy
	$	$	$
One person	5.00	2.50	0.50
Family of two	10.00	5.00	1.00
Family of three or more	12.50	6.25	1.25

(*c*) Temporary Premium Assistance is available for a three-month period under unusual circumstances which by reason of illness, disability, unemployment, or financial hardship render an eligible person unable to pay his currently required premiums for coverage under the Plan. Temporary Premium Assistance is at 90 per cent of the full premium rate.

V. LABORATORY APPROVAL

A six-member Advisory Board on Laboratories, appointed by the Commission, continues to provide advice and recommendations to the Commission pertinent to its determination of approval of laboratories for the performance of insured services under the regulations set down by the Lieutenant-Governor in Council in September 1971. The Commission is responsible for ensuring the reasonable availability of quality laboratory services for insured persons throughout the Province, of controlling the expansion of facilities or provision of new facilities until there is reasonable utilization of existing facilities, and of requiring that, where approved public facilities provide service of equal quality and availability, priority consideration be given to the services provided by such approved public facilities.

VI. PROFESSIONAL REVIEW COMMITTEES

As in the past, the Commission has continued to work closely with the peer review committees of physicians and other practitioners providing services under the Plan.

The Commission provides data to the professional licensing authorities or other relevant practitioner bodies with respect to the volume and type of services rendered under the Plan and various other statistical information on an annual basis, whenever feasible. The Commission also provides various statistical information to them on a request basis.

VII. SALARIED AND SESSIONAL

While most medical services in British Columbia are paid for on a fee-for-services basis, there is, nevertheless, a substantial volume of services paid on a salary or sessional fee basis.

Apart from the Provincial Government, which employs physicians in this way, there are many other organizations within the Province which make arrangements with physicians to provide insured services on this basis and arrange with the Medical Services Commission for reimbursements of their costs.

When the Medical Services Commission reimburses an organization which employs a doctor performing insured services on a salaried basis, a payment is made to the organization for the shareable portion of the doctor's salary, that is the proportion of the salary which represents the time he spent on providing insured services to individuals. An additional amount is paid to cover the relevant overhead costs of the organization employing the doctor. A sessional fee is a payment of a set amount of money for the services of a physician for half a day (three and one-half hours) and the sessional fee includes, where pertinent, a payment for overhead, which goes to the physician because of his continuing overhead costs in his additional private practice.

In the year 1973/74 the total expenditure on medical services by the Medical Services Comission was $171,451,447.08, which was made up of $163,511,364.74 in the form of fee-for-service payments and $7,940,082.34 for salary and sessional payments.

HIGHLIGHTS

The administration of the Medical Services Plan has been through three nonprofit societies—the British Columbia Medical Plan, C.U. & C. Health Services Society, and Medical Services Association.

During the year 1973/74 the decision was made to amalgamate administration of the whole Plan to the central offices in Victoria, directly under the Commission. This will mean the gradual phasing-out of the licensed carriers. The first step in this change was the dissolution of the British Columbia Medical Plan, effective March 31, 1974. The portion of the Medical Services Plan which has been operated by that society formed the nucleus of the direct administration of the Plan by the Commission; the other two licensed carriers will be similarly phased out by July 1975 and the administrative responsibilities now assigned to them as licensed carriers will be handled by the Commission.

Temporary premium assistance was introduced in 1973/74. This was brought about by an amendment to the *Medical Grant Act,* assented to November 7, 1973, for commencement January 1, 1974. This amendment provides, on application, temporary assistance for a period of three months at 90 per cent of the premium payable to an eligible person who by reason of illness, disability, unemployment, or financial hardship is unable to pay his premium for coverage under the Medical Services Plan of British Columbia.

There were several changes in and an addition to benefits during 1973/74, including, for chiropractic services, the limit of $50 per patient and $100 per family per year was increased to $75 per person under age 65 years and $100 per person age 65 years and over per year, effective January 1, 1974; an important new benefit

effective from April 1, 1973, was the provision of orthodontic service for an insured person 20 years of age or less for the care of a cleft lip and (or) cleft palate provided by a dental surgeon as part of a plastic surgery repair performed by a medical practitioner.

STATISTICAL HIGHLIGHTS

Under the Plan the total expenditure for insured benefits for insured persons rose from $153,452,505 in 1972/73 to $176,568,498 in 1973/74, an increase of 15.06 per cent. These figures include $6,025,920 in 1972/73 and $8,037,662 in 1973/74 for services rendered by physicians on a salaried or sessional or contract basis. Total expenditures, including administrative costs, were $160,772,642 in 1972/73 compared to $185,150,292 in 1973/74.

The number of persons covered has risen from 2,324,392 at March 31, 1973, to 2,427,853 at March 31, 1974, an increase of 4.45 per cent.

The cost of medical insured services (shared by the Federal Government) has risen from $60.30 per insured person in 1972/73 to $65.17 per insured person in 1973/74, an increase of 8.08 per cent. The most noticeable increases are in Laboratory and Radiology services, and General Practice services, which in total account for $2.99 per person of the increased per person costs.

The cost of additional benefits (not shared by the Federal Government) increased from $3.38 to $3.59 per insured person per year from 1972/73 to 1973/74, an increase of 6.21 per cent. The most significant part of this increase was in chiropractic and optometric insured services, which increased approximately 17 cents and 13 cents per insured person per year, respectively.

The statistics reflect an upward revision to the agreed schedule of costs for medical practitioners and other remuneration for insured services of physicians and surgeons, together with certain changes effecting an increase in cost for the services of practitioners providing additional insured benefits during the year. Also, increased administrative salaries and other costs are reflected in the total increased expenditures for the year. Increased population, of course, affected gross expenditures.

SECTION II

STATISTICAL TABLES

PART I—SUBSCRIBER STATISTICS

Table I—Registrations and Persons Covered[1] by Premium Subsidy Level at March 31, 1974

Subsidy (Per Cent)	Subscribers	Persons
90	227,730	378,213
50	29,237	55,913
Nil	771,932	1,993,727
Totals	1,028,899	2,427,853

Table II—Persons Covered[1] by Age-group at March 31, 1974

Age-groups	Persons
Under 1	29,893
1– 4	155,911
5–14	463,635
15–24	462,545
25–44	620,157
45–64	466,025
65–69	76,099
70–79	95,287
80–89	44,873
90 and over	6,951
Unknown	6,477
Total	2,427,853

[1] Coverage data do not include members of the Canadian Armed Forces, RCMP, and inmates of Federal penitentiaries.

Figure 1—Coverage by Age-group at March 31, 1974

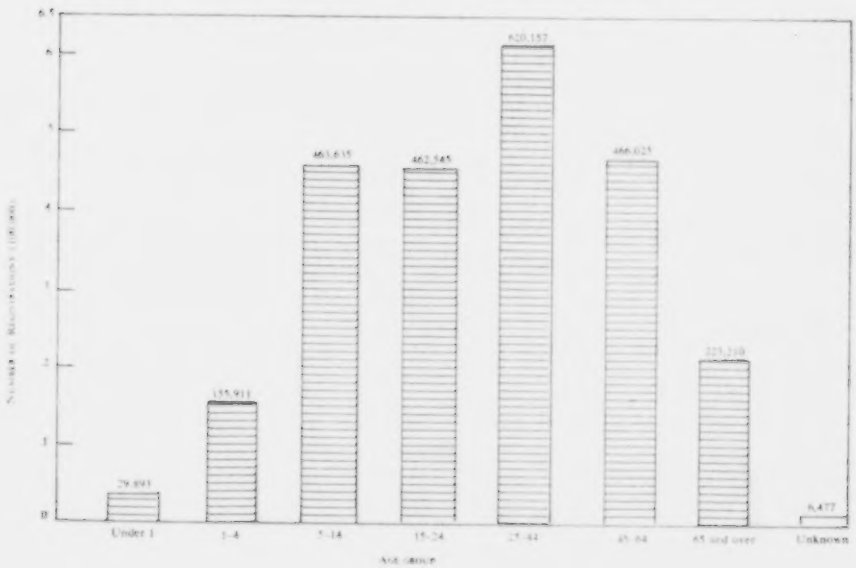
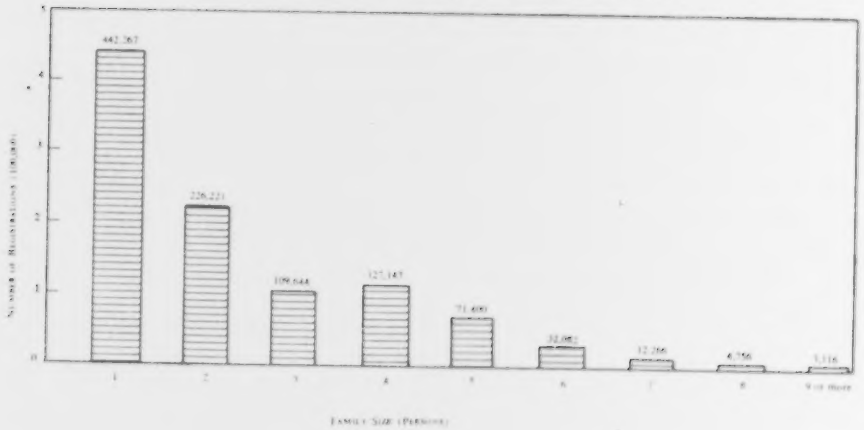


Table III—Coverage by Family Size at March 31, 1974

Family Size (Persons)	Number of Families
1	442,267
2	226,221
3	109,644
4	127,147
5	71,400
6	32,082
7	12,266
8	4,756
9 or more	3,116
Total	1,028,899

Figure 2—Coverage by Family Size at March 31, 1974



PART II—FEE FOR SERVICE PAYMENTS

Medical Practitioners and Dental Surgery in Hospital (Shareable under *Medical Care Act*, Canada)

Table IV—Distribution of Fee-for-service Payments for Medical Services (Shareable)

Specialty	Amount Paid		Percentage of Total		Cost per Person[1]	
	1972/73	1973/74	1972/73	1973/74	1972/73	1973/74
	$	$			$	$
General practice	60,912,426	67,487,760	44.52	43.59	26.8463	28.4086
Dermatology	1,307,189	1,575,525	0.96	1.02	0.5761	0.6632
Neurology	1,080,077	1,202,646	0.79	0.78	0.4760	0.5062
Psychiatry	4,521,694	4,662,309	3.30	3.01	1.9929	1.9626
Neurology and psychiatry	152,418	167,264	0.11	0.11	0.0672	0.0704
Obstetrics and gynæcology	5,487,124	6,052,637	4.01	3.91	2.4184	2.5478
Ophthalmology	5,306,415	6,162,574	3.88	3.98	2.3387	2.5941
Eye, ear, nose, and throat	49,767	49,750	0.04	0.03	0.0219	0.0209
Otolaryngology	2,673,387	2,875,681	1.95	1.86	1.1783	1.2105
General surgery	11,129,160	11,734,262	8.13	7.58	4.9050	4.9395
Neurosurgery	935,761	1,046,138	0.68	0.68	0.4124	0.4404
Orthopædic surgery	3,275,373	3,641,230	2.39	2.35	1.4436	1.5328
Plastic surgery	1,021,707	1,130,061	0.75	0.73	0.4503	0.4757
Thoracic surgery	854,435	996,843	0.62	0.64	0.3766	0.4196
Urology	2,387,985	2,621,390	1.82	1.69	1.0965	1.1035
Pædiatrics	3,139,415	3,481,484	2.30	2.25	1.3837	1.4655
Internal medicine	7,787,338	9,674,018	5.69	6.26	3.4322	4.0727
Radiology	10,418,018	11,888,791	7.61	7.69	4.5916	5.0045
Pathology	6,517,049	9,229,333	4.76	5.96	2.8705	3.8850
Anæsthesiology	6,021,962	6,412,213	4.40	4.14	2.6541	2.6992
Physical medicine	231,914	241,070	0.17	0.16	0.1022	0.1015
Public health	61,355	85,518	0.05	0.06	0.0270	0.0360
Dental surgery in hospital	405,351	455,552	0.03	0.29	0.1791	0.1918
Unclassified[2]	1,046,589	2,552,748	0.77	1.65	0.4613	1.0746
Totals	136,820,906	154,817,797	100.00	100.00	60.3018	65.1697

[1] Based on the average of insured persons in the Province during the 12 month period ending the 31st day of March (1972/73, 2,268,935; 1973/74, 2,375,609).

[2] Includes osteopathic services for last quarter of 1972/73 and all of 1973/74.

Table V—Distribution of Medical Fee-for-service Payments and Services by Type of Service

	Number of Services		Amount Paid	
	1972/73	1973/74	1972/73	1973/74
			$	$
General Practitioners				
Complete examination	514,689	567,390	7,046,932	7,808,266
Partial examination	3,471,692	3,650,467	22,915,264	25,849,320
Subsequent office visit	1,921,437	1,923,942	8,184,826	8,634,121
Night, Sunday, holiday, or emergency visit	359,274	375,470	4,770,808	6,498,828
First house visit	110,378	101,839	1,042,148	1,317,060
Subsequent house visit	54,616	401,641	52,213	535,727
Hospital visit	1,617,179	1,530,767	6,035,270	5,777,174
Subtotals	8,049,265	8,551,516	50,047,461	56,420,496
Specialist				
Consultation	590,732	630,684	14,015,932	16,264,180
House visit	3,771	4,521	62,420	106,323
Office visit	299,950	323,539	1,635,758	1,869,621
Hospital visit	366,551	385,444	2,035,407	2,458,908
Subtotals	1,261,004	1,344,188	17,749,517	20,699,032
Other Medical				
Anæsthesia[1]	1,414,732	1,630,180	7,743,922	8,352,549
Obstetrics	47,983	47,563	5,239,159	5,585,280
Surgery	412,425	404,842	22,163,025	23,330,098
Special procedures	504,683	539,372	5,526,714	6,238,480
X-ray	908,508	964,235	10,737,930	11,949,275
Laboratory	3,435,450	4,062,663	9,233,517	12,456,976
Common office procedures	1,089,749	1,124,610	4,287,725	4,619,943
Psychotherapy	200,691	197,098	3,545,750	3,676,585
Electrodiagnosis	13,350	13,918	289,063	303,775
Miscellaneous	10,428	10,987	—92,305	1,185,310
Subtotals	8,037,999	8,995,468	68,674,500	77,698,271
Totals	17,348,268	18,891,172	136,471,478	154,817,799

[1] Unit of services was changed in 1972/73, making data unsuitable for comparison.

[2] Adjustments included in amount paid, but not included in number of services. Includes osteopathic services for last quarter of 1972/73 and all of 1973/74.

Table VI—Average Fee-for-service Payments by Type of Practice[1]

Type of Practice	Number of Active Practitioners[2]		Average Payment[2]		Median Payment[2]	
	1972/73	1973/74	1972/73	1973/74	1972/73	1973/74
			$	$	$	$
General practice	1,212	1,304	45,028	46,396	43,690	46,365
Dermatology	25	26	51,712	57,949	47,712	53,496
Neurology	17	18	51,155	58,352	41,488	64,731
Psychiatry	91	94	41,974	42,026	42,236	43,447
Neuropsychiatry	2	2	68,372	77,421	68,372	77,421
Obstetrics and gynæcology	92	98	55,884	58,911	53,099	57,903
Ophthalmology	94	103	55,577	58,843	54,250	56,075
Otolaryngology	42	44	62,617	65,586	59,585	63,645
General surgery	145	143	53,324	57,944	52,816	55,058
Neurosurgery	17	19	50,687	54,447	46,142	55,916
Orthopædic surgery	60	65	53,642	54,159	51,368	52,676
Plastic surgery	19	20	53,599	56,300	48,488	56,657
Thoracic and cardiovascular surgery	11	12	74,327	92,041	74,853	80,431
Urology	46	47	54,308	55,065	52,074	53,988
Pædiatrics	39	41	44,841	50,375	43,680	48,221
Internal medicine	107	123	48,290	53,784	43,173	51,683
Anæsthesia	138	149	41,863	42,191	42,189	42,704
Eye, ear, nose, and throat	1	1	27,458	23,795	27,458	23,795
Physical medicine	5	5	33,019	42,855	30,900	42,112
Osteopathy[3]	1	3	20,541	47,426	20,541	40,407
Surgery, general practice[4]	14	18	37,881	39,951	36,973	37,338
Pædiatrics, general practice[4]	22	20	45,555	55,115	39,111	46,731
Internal medicine, general practice[4]	27	22	34,208	37,611	33,765	35,490

[1] Type of practice is based on practice being carried out rather than on certification.
[2] Includes only those physicians whose services on a fee-for-service basis grossed $20,000 or more.
[3] Osteopathic services were considered to be nonshareable until the last quarter of 1972/73.
[4] These are special classifications created for statistical purposes. Physicians in these categories are certified specialists, but derive 50 per cent or more of their income from general practice services.

PART III—ADDITIONAL BENEFITS

Fee-for-service Payments, Nonshareable by Federal Government

Table VII—Distribution of Fee-for-service Payments for Insured Services, Nonshareable Additional Benefits

Type of Service	Amount Paid[1]		Percentage of Total		Cost per[2] Person	
	1972/73	1973/74	1972/73	1973/74	1972/73	1973/74
	$	$			$	$
Special nursing	4,815	5,553	0.06	0.07	0.0021	0.0023
Victorian Order of Nursing	165,069	160,451	2.15	1.88	0.0728	0.0675
Red Cross	14,774	14,474	0.19	0.17	0.0065	0.0061
Chiropractic	3,291,202	3,786,595	42.95	44.45	1.4505	1.5939
Naturopathic	179,435	203,401	2.34	2.39	0.0791	0.0856
Physiotherapy (office)	946,416	1,162,965	12.35	13.65	0.4171	0.4895
Physiotherapy (hospital)	449,353	157,703	5.86	1.85	0.1980	0.0664
Orthoptic	2,769	2,721	0.04	0.03	0.0012	0.0011
Podiatry	815,286	899,308	10.64	10.56	0.3593	0.3786
Optometric	1,763,569	2,125,745	23.02	24.95	0.7773	0.8948
Unclassified	29,359	110	0.38	0.00	0.0130	0.0000
Totals	7,662,047	8,519,026	100.00	100.00	3.3769	3.5860

[1] These amounts are fee-for-service payments paid under the Plan only and in no way reflect the total for the services of these practitioners.

[2] Based on the average number of insured persons in the Province during the 12-month period ending the 31st day of March (1972/73, 2,268,935; 1973/74, 2,375,609).

Table VIII—Average Fee-for-service Payments by Type of Practice, Nonshareable Additional Benefits

Type of Practice	Number of Active[1] Practitioners		Average Payment[1]		Median Payment	
	1972/73	1973/74	1972/73	1973/74	1972/73	1973/74
			$	$	$	$
Chiropractic	137	145	22,991	25,106	21,667	23,026
Naturopathic	6	7	23,694	25,332	24,532	23,209
Physiotherapy	28	38	25,321	24,425	20,475	22,648
Podiatry	23	22	32,381	37,859	33,325	36,483
Optometry	95	108	15,492	17,533	13,743	16,370

[1] Includes only those practitioners whose payments from the British Columbia Medical Services Commission grossed $10,000 or more. It must be emphasized that these payments in no way represent the practitioners' total income or net income.

SECTION III

FINANCIAL STATEMENTS

Exhibit A

THE MEDICAL SERVICES PLAN OF BRITISH COLUMBIA
OPERATED BY AND UNDER THE
MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA

STATEMENT OF FINANCIAL POSITION

as at March 31, 1974

ASSETS	$
Cash	3,840,830
Investments	60,000,000
	63,840,830
LIABILITIES AND RESERVE	
Estimated liability for unpresented and unprocessed benefit costs	
Medical care	34,822,099
Additional benefits	1,881,552
	36,703,651
Premiums paid in advance	9,328,042
Contingency reserve—Exhibit B	17,809,137
	63,840,830

Approved on behalf of the Commission.

G. A. STEWART
Chairman, Medical Services Commission of British Columbia

AUDITOR'S REPORT

I have examined the statement of financial position of The Overall Medical Services Plan of British Columbia and its licensed carriers operating under the direction and control of the Medical Services Commission of British Columbia as at March 31, 1974, and the related statement of operations and contingency reserve for the year then ended. My examination included a general review of the accounting procedures and such tests of accounting records and other supporting evidence as I considered necessary in the circumstances.

In my opinion these financial statements present fairly the financial position of The Overall Medical Services Plan as at March 31, 1974, and the results of its operations for the year then ended, in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

June 28, 1974
Victoria, B.C.

J. W. MINTY, C.A.
Comptroller-General
Province of British Columbia

Exhibit B

THE MEDICAL SERVICES PLAN OF BRITISH COLUMBIA
OPERATED BY AND UNDER THE
MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA

STATEMENT OF OPERATIONS AND CONTINGENCY RESERVE
for the year ended March 31, 1974

	$	$
INCOME		
Province of British Columbia sources		
Subscribers' premiums	84,989,930	
Adjustment of provision for prepaid premiums	425,648	
	84,564,282	
Government of British Columbia	19,279,047	
Investment income	3,977,684	
		107,821,013
Federal sources		
Government of Canada—*Medical Care Act*		70,696,637
		178,517,650
EXPENDITURE		
Benefits		
Medical care	162,757,882	
Additional benefits	8,693,565	
	171,451,447	
Adjustment of provision for unpresented and unprocessed benefit costs	5,117,051	
		176,568,498
Administration		
Licensed carriers		
Salaries and employee benefits	5,183,167	
General office expenses	2,742,360	
		7,925,527
Medical Services Commission		
Salaries and employee benefits	253,276	
General office expenses	402,991	
		656,267
		185,150,292
Excess of expenditure over income		6,632,642
Contingency reserve at beginning of year		24,441,779
Contingency reserve at end of year—Exhibit A		17,809,137

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1974

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